Bethania Lutheran School

Year ..... Camp

Medical and Permission Form

PLEASE RETURN TO THE SCHOOL BY

Students full name:_____ Date of birth:_____

Permission

I _____(parent's name) give my child _____

permission to attend the year ..... camp to .
I have read and understood the letter containing details of transport and activities in which my child will be involved.

Parent's signature:_____ Date:

Parent/Carers Details

Name(s):_____

Home ph:_____ Work:_____

Mobile(s):_____

Emergency Contact Details

1. Name: _____ Relationship to child;_____

Home ph:_____ Work:_____ Mobile:_____

2. Name: _____ Relationship to child:_____

Home ph:_____ Work:_____ Mobile:_____

Medical Contacts

Family Doctor Name:_____ Phone:_____

Family Dentist Name:_____ Phone: _____

Medical History

Do you suffer from any of the following?

1.	Asthma	☐ Yes	☐ No	If yes go to Asthma management plan
2.	Allergies	☐ Yes	☐ No	If yes go to Allergy management plan
3.	Heart condition	☐ Yes	☐ No	
4.	Sight or Hearing disorder	☐ Yes	☐ No	
5.	Diabetes	☐ Yes	☐ No	
6.	Epilepsy	☐ Yes	☐ No	
7.	Bleeding disorder	☐ Yes	☐ No	
8.	Muscular/skeletal - Ankle/back/knee/joint problems	☐ Yes	☐ No	
9.	Headaches/migraines	☐ Yes	☐ No	

Medical History Cont.

10. Nose Bleeds	☐ Yes	☐ No
11. Bed wetting	☐ Yes	☐ No
12. Fear/anxieties	☐ Yes	☐ No
13. Any other conditions	☐ Yes	☐ No

If you answered yes to any of the above please provide details.

Dietary Requirements

Please list any special dietary requirements eg gluten free, nut allergy

ALLERGY TO MEDICATIONS

Is your child allergic to any medications? ☐ Yes ☐ No

If yes please provide details

_____

_____

_____

_____

_____

CONSENT TO MEDICAL ATTENTION

Where the teacher or first aid officer in charge is unable to contact the parent/caregiver, or contact is impracticable, I authorise the teacher in charge or first aid officer to:

- consent to my child receiving such medical, surgical or operative treatment (including general anaesthetic) as may be deemed necessary by the appropriate medical authorities.
- administer such first-aid as the teacher in charge or first aid officer may judge to be reasonably necessary.

Furthermore, I agree that the School or its agents will not be held responsible for any expenses so incurred.

I declare that the information provided on this form is complete and correct.

Parent/Carer Signature: _____

Date: _____

CONSENT TO ADMINISTER PANADOL

Where the teacher or first aid officer is unable to contact the parent/care giver, or contact is impracticable eg location or late at night, I authorise the teacher or first aid officer to administer panadol. (Liquid panadol will be taken with us to camp)

Parent/Carer Signature: _____

Date:_____

ASTHMA MANAGEMENT PLAN

Regular Medication: _____

Quantities and Dosages:_____

Additional Medications in case of an attack: _____

_____

Do you know of any trigger factors?: _____

Peak flow readings - Expected best: _____

Have you ever required emergency medical assistance? _____

Any other important information**:** _____

_____

_____

Name: _____ **Signature:** _____

ALLERGIC REACTION MANAGEMENT PLAN

Allergy: _____

Signs and Symptoms: _____

What medication do you take (if any)
for prevention of an allergic reaction?_____

What treatment is followed for an allergic reaction? _____

_____

Have you at any time, suffered from any of the following?

☐ A localised reaction (any rash/itching/swelling at the sight of where poison has entered)

☐ A systemic reaction (any rash/itching/swelling away from the sight where the poison has entered)

☐ An anaphylactic reaction (severe breathing problems, swelling of body, emergency situation)

Do you suffer a systemic / anaphylactic reaction to allergy? ☐ Yes ☐ No

Is there a family history of anaphylaxis? ☐ Yes ☐ No

Have you ever been admitted to hospital for an allergic reaction? ☐ Yes ☐ No

Do you take adrenaline (Epi-Pen) when suffering an allergic reaction? ☐ Yes ☐ No

Name:_____ Signature:_____

MEDICATION TO BE ADMINISTERED ON CAMP

Any medication to be administered on the camp must be handed in to Miss Gillanders on Friday 16th and be clearly labelled by a physician/pharmacist with the students name and dosage requirements. Please place medication in a clear, zip lock bag clearly labelled with the students name.
If it is necessary for your child to carry their own medication (for example asthma puffers) it must be with the knowledge of Miss Gillanders and the parent/carer.

PERMISSION TO ADMINISTER MEDICATION (To be completed for any child requiring medication)

Medication: _____

Dose: _____

Time of Administration: _____

If medication is to be administered in an emergency please give symptoms eg for coughing, when breathless

_____

_____

_____

Medication Prescribed By: _____

Reason for Medication: _____

Parent/Carer's Signature: _____

Please Print Name: _____

Date: _____